

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/13/2012	
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit [PSR] to the investigation of Complaint IN00108396.</p> <p>Complaint IN00108396----corrected</p> <p>This visit was done in conjunction with the PSR to the Recertification and State Licensure survey and the investigation of Complaint IN00110677, IN00109548, IN00110489, & IN00111027.</p> <p>Survey date: August 13, 2012</p> <p>Facility number: 000022 Provider number: 155061 AIM number: 100274510</p> <p>Survey team: Angel Tomlinson RN TC Barbara Gray RN</p> <p>Census bed type: SNF: 3 SNF/NF: 38 Total: 41</p> <p>Census payor type: Medicare: 3 Medicaid: 38 Total: 41</p> <p>Sample: 3</p> <p>Woodland Hills Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the investigation of Complaint IN00108396.</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 08/13/2012
NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Quality review completed 8/15/12 Cathy Emswiller RN	{F 000}			